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Males Experiencing Childhood Sexual Abuse and Their Associations with Psychological Distress

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MALES EXPERIENCING CHILDHOOD SEXUAL ABUSE AND THEIR ASSOCIATIONS WITH PSYCHOLOGICAL DISTRESS

by

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ABSTRACT
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Childhood sexual abuse (CSA) is an important issue relatively recently beginning to gain attention from professionals. Studies show that males are underrepresented in the literature, although CSA is a prevalent problem for males as well as females. This study was developed to add to the existing literature on males and CSA, obtain prevalence rates from a nationally representative, epidemiological study, and find correlates between CSA and psychological distress factors. The epidemiological study used was the National Comorbidity Study-Replication (NCS-R). This was a large survey of U.S. households investigating correlates and comorbidities of psychological disorders. Secondary analyses were completed on the NCS-R including prevalence rates of CSA in men compared to women, racial/ethnic information of men, associations with psychopathology as a function of CSA history in men, and demographical differences. It was found that there is indeed a significant difference between men with and without a history of CSA on race/ethnicity, socio-economic issues, psychological disorders, substance use, suicidality, use of mental health services, and experiencing other traumatic events, especially those involving interpersonal violence. Implications include support for increased use of screening for CSA within professional services that men with CSA have increased use of, including mental health and substance abuse services.

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Childhood sexual abuse (CSA) is a prevalent and complex problem. This problem is nothing new; however, empirical research about and professional attention to it are relatively recently beginning to grow. It is problematic to find any research on childhood sexual abuse before the past few decades. One of the first epidemiological studies on CSA was by Greenberg, 1979, in which prevalence rates of CSA in the United States were addressed, lack of consistent definitions for CSA, and previous theories about CSA. One previous theory, widely disregarded now, about CSA postulated that children were to be held responsible for their abuse because of seducing the perpetrator (Greenberg, 1979). An article published the following year wrote about the treatment and detection sexual abuse of children just beginning to gain momentum. The article cites the increased awareness of CSA due to more attention by professionals, better communication between services and victims, increased availability of community services, and more protective methods for child victims to disclose abuse (Shamroy, 1980). However, empirical articles on CSA were still very rare during the early 1980s. Fortunately, literature has considerably increased on childhood sexual abuse, especially after 1985 (Kendall-Tacket et al., 1993).

Although the growing amount of literature is important, there is a clear imbalance of literature with the number of female CSA articles exceeding those on males (Valente, 2005; Walker et al., 2004). This was further evidenced by a keyword search we completed in the PsycInfo database. When searching childhood sexual abuse (in any field) AND females (as subjects) the number of articles found was 1,524 but when using males as subjects the search yielded 388 articles. When searched in MedLine (PubMed) using childhood sexual abuse AND females (in any field) yielded 3,249 articles, while

males yielded 2,102 articles. Why the imbalance? One may think because the prevalence rate for males experience CSA is much lower than that of females, or that it is extremely rare. This is however not exactly the case. Articles reviewed here that investigated male and female participants did present data that show higher rates of CSA in females, but the rates of CSA in males shows it is nothing rare.

In one study reviewing gender differences on prevalence of CSA and PTSD it was found that on average the rate of CSA in females is 5.8-34% and for males 2-11% (Walker et al., 2004). Other studies, Asoved et al. (2011), Menard et al. (2003), Alaggia et al. (2008), Valente (2005), cite male CSA rates to be: 2-15%, 5-10%, 4-9%, and 4-16%, respectively. On one hand, these prevalence rates tell us that we know CSA is definitely happening in males, with alarming prevalence. On the other hand, these rates are quite different with wide ranges of occurrence, which tells us we don't know very well how prevalent this is.

Adding to the complexity of determining prevalence rates includes the lack of consistent definitions of what constitutes CSA. Some researchers conclude that CSA covers a wide range of behaviors between a child and someone of higher age, often having to be at least five years older, and higher power, both physically and psychologically (Walker et al., 2004; Valente, 2005). These behaviors can include removal of clothing, fondling, manual stimulation, exhibition, and penetration, including digital, genital, or using an object, of any bodily orifice (Valente, 2005). More generally, a definition of CSA commonly used comes from the National Center for Child Abuse and Neglect, 1981, "contact or interaction between a child and an adult when the child is used for the sexual stimulation of an adult or another person," (Walker et al., 2004). In

addition to differing definitions of acts of CSA, there is not a consistent age limit as to who is still considered a child in the case of sexual abuse. One study found a commonly used criterion for age includes a child aged 12 or under abused by a perpetrator at least five years older and children 13 – 16 years abused by a perpetrator at least 10 years older (Lloyd & Operario, 2012). However, two meta-analyses on CSA set their inclusion criterion for age of childhood abuse at 18 (Butt et al., 2011; Kendall-Tackett et al., 1993). Differing definitions and criteria on childhood sexual abuse makes it difficult to synthesize findings and make conclusions.

Because of limited knowledge of male CSA, its prevalence is often difficult to determine and therefore can be underestimated (Walker et al., 2004). Discrepancies related to male CSA prevalence may also come from differences in sample population, sampling technique, clinical versus non-clinical samples, definition of sexual abuse, and data gathering methods (Alaggia & Millington, 2008; Walker et al., 2004; Young et al., 2011). This underestimation may increase the stigmatization associated with males being sexually abused, reduce the likelihood of males disclosing CSA, and as a result they may feel they are more alone than they really are. Men often report feeling helpless, isolated, guilty, weak, shameful, or "unmanly" from having been abused which may also keep them from disclosing (Alaggia & Millington, 2008; Valente, 2005). These unfortunate stigmatizations and the misconception of being alone in their experience may keep some men from seeking the support or treatment that they may need.

Numerous psychological and physical issues have been shown to develop in some people following childhood sexual abuse, for which it is important to seek support or treatment. Experiencing CSA can have a substantial impact on the survivor's emotional

and cognitive development. After abuse has occurs the child is left to make sense of an incomprehensible situation. The survivor's sense of self can be left quite damaged and inappropriate coping skills can develop. Some boys may display sexualized behaviors, abuse others, induce self-hypnosis or dissociation, rage, extreme passivity, violence, or self-mutilation. The damaged emotional and cognitive development in childhood can lead to clinical issues later in life. When compared to non-abused counterparts, boys who have experienced CSA have a two to four times higher likelihood of developing clinical sequelae (Valente, 2005). These issues often include depression, borderline personality disorder, anxiety disorders, posttraumatic stress disorder, substance abuse, suicidal behaviors, academic problems, aggression, sexualized behaviors, and more frequent health service needs. These issues can emerge during adulthood, not necessarily only directly after the childhood experience (Alaggia & Millington, 2008; Butt et al., 2011; Hovey et al., 2011; Kendall-Tackett et al., 1993; Rosenthal et al., 2005; Valente, 2005; Young et al., 2011).

Substance abuse was reported as an important variable associated with CSA by all of the articles previously cited. It was the main outcome variable investigated in a meta-analysis done by Butt et al. (2011). It was found that there is an association between CSA and illicit drug use, specifically regarding frequency, multiple drug use, risk and severity of illicit drug use, and use of crack-cocaine. However, there was no association between CSA and early experimentation with drugs, drug problems and illicit drug use at the time of study. More generally, men who have experienced CSA are at greater risk for substance use problems than non-abused men. This conclusion was supported by many studies reviewed; however, not all supported this, therefore it is difficult to make solid

conclusions about CSA and later substance use. Knowing that there can be an association with these two factors and that men can be reluctant to self-disclose unprovoked, it could be useful to include a screening for CSA in men undergoing substance use treatment. Unknown CSA may complicate treatment as it could appear that the client is resistant or unresponsive when in actuality he is suffering from other issues. Screening for CSA can facilitate treatment of substance use problems and possibly other comorbidities that may occur (Butt et al., 2011).

Some survivors do develop symptoms and clinical sequelae; however, this is not to say that all survivors of childhood sexual abuse will develop clinical sequelae, substance abuse problems or other issues; in fact, one study found that there is weak correlation between the abuse and psychological adjustment (Valente, 2005). Some findings on CSA and symptomology assert that 21-49% of sexually abused children are actually asymptomatic. This could be due to a child's effective ability to cope with their experience, but it could also be indicative of ineffective measures of symptoms. The symptoms a child may have might not have been captured by the measures used, symptoms might manifest later in life, or the child could be suppressing symptomology (Kendall-Tackett et al., 2003). Nevertheless, it is still important to investigate those who have experienced CSA for subsequent psychological or physical consequences and finding the support they may need.

Many studies on male childhood sexual abuse do mention clinical sequelae that can result from the abuse; however, less is known about the impact of treatment or support on the development of said sequelae (Valente, 2005). Even less is known about the specific results in men only. Most studies on CSA either focus on females or females

and males mixed (Asoved et al., 2011). Specific numbers of studies mentioned above show that men only as a group are under studied. Additionally, a literature review of male CSA, Valente (2005) declares a need for quantitative studies to be completed on large, national samples to elucidate detection of CSA, evaluation and treatment of these males who have experienced CSA. It must be investigated if treatment is helpful for those who develop clinical sequelae and the results of going without treatment. If treatment is found to help reduce clinical sequelae, we then must wonder how to extend services to men who need them. As mentioned before, there is underreporting from men who have experienced CSA and they may be reluctant to seek these services.

The need for additional quantitative research of male childhood sexual abuse prompted the formation of this study, which used a national dataset to complete secondary analyses. The dataset is from the National Comorbidity Survey Replication (NCS-R). This nationally representative survey, of the United States, interviewed over 9,000 participants from February 2001-April 2003 to study trends and further investigate certain variables from the National Comorbidity Survey (NCS). The NCS, completed ten years earlier, used a fully structured research diagnostic interview to investigate the prevalence and correlates of DSM III-R disorders among participants. The NCS-R used the DSM-IV, 1994 criteria for their investigations. Additionally, the NCS-R was administered to participants through face-to-face interviews by trained lay interviewers. Sections were skipped as soon as it became clear that the participant did not meet the criteria for full diagnosis of the particular disorder of that section. This allowed for shortened interview length, as the survey was designed to be quite comprehensive and therefore lengthy. The NCS-R data collection and procedure are further described below.

This study investigated males who have undergone childhood sexual abuse and associations with subsequent psychological adjustment. To do so, we used the aforementioned national dataset to complete analyses on the following aims. First, we compared men who have experienced childhood sexual abuse to men who have not experienced this on several factors. These factors are as follows: Basic demographic information, to determine if there are any fundamental differences in our comparative samples; Will the CSA group have increased psychopathology, including posttraumatic stress disorder (PTSD), depression, generalized anxiety disorder, suicidality; Will the CSA group have increased use of mental health services; Will the CSA group have increased substance use, including alcohol, marijuana, cocaine, prescription, and other drugs; and Will the CSA group have higher rates of experiencing other traumatic events?

Methods and Materials

Data used: Secondary analyses were completed on the National Comorbidity Survey – Replication (NCS-R) which is a large, epidemiological survey, as partially detailed above. Interviewers completed face-to-face interviews after completing verbal informed consent with 9,282 participants, aged 18 and older, in English speaking households. Respondents were given a $50 incentive for completion; there was a 70.9% response rate. Face-to-face interviews were used over other modalities such as mail, telephone, or online, for four main reasons: greater area coverage, increased accuracy of screening, higher response rates, and the length and complexity of the survey. Interviewers used computer assisted personal interviewing (CAPI) on laptop computers to administer the survey. The survey was completed in two parts. The first part consisted of a core diagnostic assessment of all participants. Part two consisted of questions pertaining to

correlates and other disorders; this second part was only administered to those participants who met criteria for at least one lifetime diagnosis of a disorder, plus a sub-sample of about one in three of other participants. The approximate number of participants completing the second part was 5692 (Nierenberg et al., 2010). The average completion time was 2.5 hours, with some interviews taking as little as 90 minutes and some as much as 6 hours (Kessler et al., 2004).

The interview schedule of the NCS-R was a version of the World Health Organization (WHO) Composite International Diagnostic Interview (CIDI) that was developed for the World Mental Health (WMH) Survey Initiative. Other supplemental sections were added only included in the United States version. Because of the structure of the interview, participants were not asked all criteria questions of every disorder; as stated before, the interviewer moved onto another section if certain criteria were not met (Kessler et al., 2004). Therefore, we are only looking at lifetime diagnosis of a given disorder.

Participants from the NCS-R were selected to be nationally representative of English-speaking, non-institutionalized Americans aged 18 and older. Excluded states were Alaska and Hawaii. Otherwise, there were selected participants from each of the 48 contiguous states. Students living in campus housing were included as long as it was their permanent address. Only one member from each chosen household was selected to participate.

Measures: Detailed information of exact question wording and response choices can be found in the appendix.

Childhood Sexual Abuse: Four questions from the NCS-R were used to determine if CSA is present. These questions are taken from the post-traumatic stress disorder portion. The questions asked if one was ever raped, ever sexually assaulted, and at what age if so. Criteria for CSA in this study required answering "yes" to at least one of the two questions and by answering age 16 years or less to at least one of the "yes" answered questions. The age of 16 was used to follow suit with some major CSA works and is also believed to better capture childhood, rather than 17 or 18 who by law are children, or a very young adult, but are much closer to being physically and mentally adult-like.

Posttraumatic Stress Disorder, Major Depressive Disorder, and Generalized Anxiety Disorder: Lifetime diagnosis of the disorder was used as the measurement.

Suicidality: This was measured by the questions ever attempted suicide and number of times attempted suicide in the lifetime.

Use of Services: This measurement used questions that ask about several different mental health services and their usage during the lifetime.

Substance Use: Lifetime abuse and dependence of alcohol and drugs were used in this measure, as well as asking if either has interfered with work, school, job, home, family, or friends. Also, we will look at questions that ask if any of the following were ever used: marijuana, cocaine, prescription, or other drugs.

Experiencing Other Traumatic Events: Endorsement of experiencing other traumatic events, besides rape or sexual assault by age 16 or less, will be used as the measurement. See the appendix for complete list of other traumatic experiences analyzed.

Statistical analyses: These analyses were completed using IBM Statistical Package for the Social Services (SPSS) Statistics 20 software. A Pearson chi-square analysis was completed comparing men and women on rates of experiencing childhood sexual abuse. Next, we compared only men using chi-square analyses on having experienced CSA or not on categorical factors such as ethnicity, race, self-reported rank compared to other US citizens in terms of money, job, and education, ever been to jail, prison, or a correctional facility, ever received public benefits since 18, marital status, employment status, region of country, and type of city raised in. Other categorical comparisons that were analyzed by chi-squares include: presence or not of lifetime PTSD, depression, generalized anxiety disorder, suicidality, substance use, use of mental health services, and experiencing other traumatic events. We completed t-tests for independent samples to compare continuous variables such as number of times attempting suicide, self-reported SES ranking compared to others, and current age.

Results

Race and Ethnicity: All male participants from the NCS-R were included in these analyses. There were a total of 4,139 males upon which secondary analyses were completed. Of those males (n = 2834) that responded to the questions pertaining to race and ethnicity, 77% were non-Hispanic White, 10% were Black/African American, 9% were Hispanic or Latino, and the remaining 4% were American Indian, Native Hawaiian, Asian, or Pacific Islander. Other demographics were investigated within males as a function of CSA history.

Childhood Sexual Abuse: First, a chi-square analysis was completed comparing rates males and females experiencing CSA. The analysis found that females experienced CSA

at a significantly higher rate than males, 36.9% compared to 8.8% respectively, $\chi^2(1) = 415.5$, $p < 0.001$. Next, only men were compared on demographic variables as a function of experiencing CSA, see Table 1. There were no significant differences between men experiencing CSA and those not on region of country, type of city raised in, years of education completed, employment status, marital status, or having ever gone to a correctional facility, jail, or prison. There was a significant difference of having received welfare since the age of 18 and an independent samples t-test revealed that, men who experienced CSA ($\bar{x}$ = 5.6, *SD* = 1.98) rated themselves significantly lower in terms of money, education, and job prestige as compared to others in the US than men without experiencing CSA ($\bar{x}$ = 6.0, *SD* = 1.82), $t(176.5) = 2.12$, $p = 0.029$. There were significant differences on race and ethnicity, specifically men who experienced CSA were more likely to be of Hispanic or Latino descent and were more likely to be non-White, compared to men without experiencing CSA, see Table 1. However, this difference in race, White vs. non-White (Black/African American, American Indian, Asian, Pacific Islander, Native Hawaiian, or Alaska Native), was not significant when these races were not grouped together into two categories, $\chi^2(4) = 9.2$, $p = 0.056$. Also, there were too few participants in some of the racial categories for the CSA experience group in order for the Pearson chi-square analyses to be considered accurate, without grouping into two categories (White vs. Not White). There was also no significant difference in age between the CSA experience group ($\bar{x}$ = 42.3, *SD* = 14.34) and the no CSA experience group ($\bar{x}$ = 44.0, *SD* = 16.31), $t(194.7) = 1.41$, $p = 0.161$, *df* adjusted due to unequal variances.

Psychopathology: Men with a history of CSA were compared to men without it on the following factors: prevalence rates of lifetime diagnosis of posttraumatic stress disorder (PTSD), major depressive disorder (MDD), generalized anxiety disorder (GAD), and suicidality. Chi-square analyses revealed that there was indeed a significant difference between men with and without a history of CSA on those factors, see Table 2.

Suicidality was further investigated by comparing men who have endorsed attempting suicide on the number of attempts as a function of experiencing CSA or not. A t-test for independent samples revealed that there was not a significant difference in number of attempts between men experiencing CSA ($\bar{x}$ = 2.8, *SD* = 3.48) and those not ($\bar{x}$ = 1.7, *SD* = 1.88), *t* (27.2) = -1.45, *p* = 0.160, *df* adjusted due to unequal variances.

Substance Use: Men with and without a history of CSA were compared on the following: lifetime prevalence of alcohol abuse or dependence, drug abuse or dependence, use of any drug ever, if drinking ever interfered with work, school, job or home, and if drinking ever caused problems with family or friends. As displayed in Table 3, chi-square analyses reveal there was a significant difference on all variables.

Use of services: There were mixed findings on service use as a function of a history of CSA, see table 4. There was not a significant difference on ever spending the night in the hospital or the number of times hospitalized for mental health or substance use. There were significant differences on the use of specific services such as attending a self-help group for emotional problems, using a hotline for problems with emotions or nerves, going to a professional psychological counseling for 30 or more minutes, having received medications for emotional or mental health problems, having seen a professional for emotions, nerves, or substance use, and there was a strong trend for the use of an internet

support group. Overall, men with a history of CSA are more likely to endorse using multiple types of mental health services compared to men without this history.

Experience of Other traumatic events: Overall, men with a history of CSA significantly experienced most of the other traumatic events, especially when related to interpersonal violence, at higher rates than men without this history, see Table 5.

Discussion

Prevalence rates of childhood sexual abuse were found to be 8.8% for men in the general population. This is somewhat in the middle to upper range for prevalence rates from other studies (Asoved et al., 2011; Menard et al., 2003; Alaggia et al., 2008; Valente, 2005; Walker et al., 2004). This rate was significantly higher for those of Hispanic or Latino ethnicity, 13.7%, or those from a race other than white/Caucasian, 24.7%. These increased rates for racial/ethnic minorities are alarming and deserve further empirical research. Besides race or ethnicity, there were few demographical differences between men with and without a history of CSA; only having received welfare since 18 years of age was found to be significantly different and a self-reported rating compared to others in the US in terms of money, education, and job prestige. However, employment, number of years of education completed, and age were not different, which may indicate that men who experience CSA have more economic challenges or have lower paying jobs.

As hypothesized, and in line with other CSA research, there were significant differences in lifetime rates of select DSM Axis I disorders and suicidality (Alaggia & Millington, 2008; Butt et al., 2011; Hovey et al., 2011; Kendall-Tackett et al., 1993; Rosenthal et al., 2005; Valente, 2005; Young et al., 2011). Specifically, we found that

men with a history of CSA are at higher risk for PTSD, MDD, GAD, and more likely to have ever attempted suicide compared to men without this history. When comparing all men who have ever attempted suicide there were no significant differences in number of attempts between men with or without a history of CSA. It should be noted that, for obvious reasons, rates for completion of suicide could not be measured. It may be useful to investigate forensic data to find if men experiencing CSA are at increased risk for not only having ever attempted suicide but also completing it.

In addition, the analyses supported the hypothesis that there will be increased substance use seen in men experiencing CSA compared to those not experiencing CSA. Alcohol and drug abuse and dependence occur at significantly higher rates in men experiencing CSA. Additional drinking issues were more greatly associated with men experiencing CSA such as problems with friends and family and interference with work, school, or home life. This finding supports the use of a CSA screening in men seeking substance use treatment. Previous research stated that discovering this abuse may help increase the effectiveness or substance use treatment and help those men find additional resources they may need (Butt et al., 2011). Conversely, it may be useful to screen men who do endorse having experienced CSA for substance use problems.

The hypothesis that men experiencing CSA will have a higher use of mental health services was partially supported. For most service types there was a significant difference, including attending a self-help group for emotional problems, using a hotline for problems with emotions or nerves, going to a professional psychological counseling for 30 or more minutes, having received medications for emotional or mental health problems, and having seen a professional for emotions, nerves, or substance use.

Although just short of significant, there was a strong trend for the use of an internet support group ($p = 0.053$). There were not significant differences found in regards to hospitalization, specifically having ever stayed overnight in a hospital for mental health or substance use reasons. Overall, this supports the use of CSA screening in mental health intake procedures and increase professional awareness, especially because there is evidence that men are unlikely to spontaneously disclose CSA but rather when addressed by a professional (Alaggia & Millington, 2008; Valente, 2005).

Interestingly, the hypothesis that men with a CSA history will more likely than men without this history experience other traumatic events was partially supported. The CSA group was significantly more likely to experience other traumatic events that were related to interpersonal violence, such as being mugged, held up, or threatened with a weapon, witnessing physical violence at home, being kidnapped or help hostage, being badly beaten by a parent, and being stalked, which is, however, not necessary violent but an interpersonal traumatic event. Also significant, but not necessarily considered interpersonal violence was someone close dying unexpectedly and seeing atrocities or carnage. Three of the four other, non-significant, events were unrelated to interpersonal violence such as a life threatening automobile accident, a major natural disaster, and being exposed to a toxic chemical. The remaining event was experiencing combat, which by definition includes interpersonal violence; however, unlike other interpersonally violent events, combat likely could have been an experience one chooses to have, by enlisting in the military. Overall, the CSA endorsing group correlated with experiencing other traumatic events presents an interesting pattern that may be useful in future research.

One limitation of this study may be that the survey questions used for analyses were not intended to capture CSA. The questions specifically ask about rape and sexual assault besides rape at any age, although there was a follow up question that asks at what age the experience occurred. Although the wording of the sexual assault question gives some examples of what is included as sexual assault, some men might not have considered a certain childhood sexual abuse experience, such as exhibitionism or removal of clothing, as sexual assault. Another limitation may be that we are looking retrospectively at the pathology presented by men. These men may have had other life experiences contributing to the variance among factors analyzed. Also, analyzing data from adults makes it difficult to extrapolate findings to children or to discern if pathologies are resulting from CSA or another event (Kendall-Tackett et al., 1993). Additionally, the older a participant is at the time of the survey leaves more room for pathologies to diminish by treatment, support, time or any other means. This would mean missing an association between CSA and pathology that once existed, if the participant did not endorse or recognize the lifetime prevalence of a certain disorder they may have had but do no longer have.

There are many different symptoms that can emerge in those who have been abused; of course, we could not investigate all of these. One symptom that is often reported is sexualized behaviors in children whom have previously been sexually abused (Kendall-Tackett et al., 1993). There were no appropriate measures available to capture this concept. It would have been especially difficult to appropriately investigate as this survey is given to adults, so the participant would have to retroactively report symptoms. Additionally, avoidance has been shown to be associated with increased symptom

severity in those who have experienced CSA (Rosenthal et al., 2005). It was intended to measure this concept of avoidance and determine if increased symptoms were associated. However, there were too few subjects who answered the needed questions in order to measure this.

Conclusions

The purpose of this study was to add to the existing, limited, literature on men experiencing childhood sexual abuse. About average to above average with other studies, we found that the prevalence rate of CSA, by age 16, in American, non-institutionalized men to be 8.8%. Those from racial/ethnic minority backgrounds were at significantly increased risk for CSA. Men experiencing CSA were found to be at greater risk for socio-economic challenges, psychopathology including lifetime PTSD, MDD, and GAD, having attempted suicide, substance use problems, utilize mental health services, and more likely to experience interpersonal violence related traumatic events than men without experiencing CSA. Fortunately, fewer instead of greater men with a history of CSA experience these issues. However, for those who do, it is important for future research to determine the effectiveness of treatments available. Also, screening for CSA should be increased in several professional fields including, but not limited to, mental health services and substance abuse services.

Tables

Table 1. Demographics of Males Compared by CSA History			
Demographic Type	*n* (%) with CSA	*n* (%)without CSA	χ^2 (df), *p* value
Hispanic or Latino	21 (13.7%)	137 (8.6%)	**4.5 (1), 0.035**
Race (Not White)	36 (24.7%)	252 (16.2%)	**6.9(1), 0.009**
Region			4.4 (3), 0.221
Northeast	25 (16.1%)	290 (18.1%)	
Midwest	39 (25.2%)	468 (29.2%)	
South	46 (29.7%)	493 (30.8%)	
West	45 (29.0%)	350 (21.9%)	
City Type			2.7 (4), 0.613
Large City	37 (25.2%)	359 (23.0%)	
Suburbs	25 (17.0%)	319 (20.4%)	
Small City	34 (23.1%)	301 (19.3%)	
Town/Village	21 (14.3%)	266 (17.0%)	
Rural Area	30 (20.4%)	316 (20.2%)	
Education			6.8 (3), 0.080
0-11 Years	34 (21.9%)	270 (16.9%)	
12 Years	33 (21.35)	489 (30.5%)	
13-15 Years	49 (31.6%)	452 (28.2%)	
≥16 Years	39 (25.2%)	390 (24.4%)	
Employed	118 (76.1%)	1114 (69.8%)	2.8 (1), 0.097
Married	89 (57.4%)	1018 (63.6%)	3.6 (2), 0.163
Received Welfare[a]	24 (18.0%)	136 (10.0%)	**8.2 (1), 0.004**
Correctional Facility[b]	46 (32.9%)	389 (27.6%)	1.8 (1), 0.186

Note: [a] Indicates having received welfare since the age of 18
[b] Indicates having been to jail, prison, or a correctional facility since the age of 18

Table 2. DSM Axis I Disorders and Suicidality as a Function of CSA			
Disorder	*n* (%) with CSA	*n* (%)without CSA	χ^2 (df), *p* value
PTSD	30 (19.4%)	96 (6.0%)	**37.7 (1), <0.001**
MDD	51 (32.9%)	356 (22.2%)	**9.0 (1), 0.003**
GAD	28 (18.1%)	162 (10.1%)	**9.2 (1), 0.002**
Attempt Suicide Ever	24 (48.0%)	79 (27.1%)	**8.8 (1), 0.003**

Note: PTSD posttraumatic stress disorder; MDD major depressive disorder; GAD generalized anxiety disorder

Table 3. Substance Use as a Function of CSA			
Use type	*n* (%) with CSA	*n* (%)without CSA	χ^2 (df), *p* value
Any Drug[a]	113 (72.9%)	991 (62.0%)	**7.2 (1), 0.007**
Drug Abuse	49 (31.6%)	291 (18.2%)	**16.3 (1), <0.001**
Drug Dependence	24 (15.5%)	92 (5.7%)	**21.7 (1), <0.001**
Alcohol Abuse	62 (40.0%)	478 (29.9%)	**6.8 (1), 0.009**
Alcohol Dependence	31 (20.0%)	203 (12.7%)	**6.6 (1), 0.010**
Drinking Interfere[b]	43 (62.3%)	267 (49.4%)	**4.1 (1), 0.042**
Drinking Problems[c]	53 (76.8%)	341 (63.1%)	**5.0 (1), 0.025**

Note: [a] Indicates having ever used marijuana, cocaine, prescription (abuse), or other drug
[b] Indicates drinking has interfered with work, school, job or home
[c] Indicates drinking has caused problems or arguments with family or friends

Table 4. Mental Health Service Use as a Function of CSA			
Service Type	*n* (%) with CSA	*n* (%)without CSA	χ^2 (df), *p* value
Overnight Hospital[a]	14 (10.1%)	125 (8.3%)	0.6 (1), 0.456
Internet Group/Chat	5 (3.3%)	19 (1.2%)	0.053[b]
Self-Help Group	25 (16.1%)	169 (10.6%)	**4.5 (1), 0.035**
Hotline	17 (11.0%)	38 (2.4%)	**<0.001**[b]
Therapy for 30+min	84 (54.2%)	603 (37.7%)	**16.1 (1), <0.001**
Received Medications	61 (39.4%)	401 (25.1%)	**14.8 (1), <0.001**
Seen Professional	11 (22.0%)	65 (8.4%)	**0.004**[b]

Note: [a] Indicates having stayed overnight in a hospital for mental health or substance use
[b] Fisher's Exact Test (Exact significance 2-sided) used due to low number of participants in certain cells of the cross-tabs output

Table 5. Experiencing Other Traumatic Events as a Function of CSA			
Traumatic Event	*n* (%) with CSA	*n* (%)without CSA	χ^2 (df), *p* value
Mugged, held up, threatened w/weapon	84 (59.6%)	653 (40.8%)	**18.7(1), <0.001**
Witness physical fights at home	52 (33.5%)	289 (18.1%)	**21.5(1), <0.001**
Kidnapped or hostage	57 (43.5%)	53 (10.8%)	**76.5(1), <0.001**
Badly beaten by parent	41 (32.8%)	163 (11.5%)	**45.4(1), <0.001**
Ever stalked	23 (14.8%)	111 (6.9%)	**12.5(1), <0.001**
Someone close die unexpectedly	92 (59.7%)	781 (48.8%)	**6.7(1), 0.010**
See Atrocity/Carnage	31 (20.0%)	205 (12.8%)	**6.3(1), 0.012**
Combat	18 (11.6%)	213 (13.3%)	0.4(1), 0.546
Life threat car accident	34 (35.1%)	408 (38.5%)	0.4(1), 0.505
Natural Disaster	49 (44.5%)	451 (36.5%)	2.8(1), 0.093
Expose Toxic Chemical	21 (17.8%)	195 (15.6%)	0.4(1), 0.532

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APPENDIX: LIST OF NCS-R QUESTIONS AND RESPONSE CHOICES

1. **Demographic Variables**
    a. Are you of Hispanic or Latino descent -- that is, Mexican, Mexican American, Chicano, Puerto Rican, Cuban, South or Central American or other Spanish culture or origin?
        i. Not Spanish/Hispanic
        ii. Mexican
        iii. Mexican American
        iv. Chicano
        v. Puerto Rican
        vi. Cuban
        vii. South/Central American
        viii. Other Spanish (specify)
    b. Which of the following best describes your race: American Indian, Alaska Native, Asian, black or African American, Native Hawaiian, Pacific Islander, or white?
        i. White/Caucasian
        ii. Black/African American
        iii. American Indian
        iv. Alaska Native
        v. Asian
        vi. Native Hawaiian
        vii. Pacific Islander
    c. Since the age of 18, were you ever in a jail, prison, or correctional facility?
        i. Yes
        ii. No
        iii. (If vol “political prisoner”)
    d. Have you ever received public assistance or welfare since turning age 18 - such as Aid to Families with Dependent Children, General Assistance, or Temporary Assistance for Needy Families?
        i. Yes
        ii. No
    e. Think of this ladder as representing where people stand in the United States. At the top of the ladder are the people who are the best off - those who have the most money, the most education and the most respected jobs. At the bottom are the people who are the worst off - who have the least money, least education, and the least respected jobs or no job. The higher up you are on the ladder, the closer you are to the people at the very top; the lower you are, the closer you are to the people at the very bottom.

i. (Participant chooses number 1 – 10, with 10 being highest on the ladder)

f. Work status 3 categories
   i. Employed
   ii. Unemployed
   iii. Not in labor force

g. Were you raised mostly in a large city, suburbs of a large city, a small city, a town or village, or in a rural area?
   i. Large City
   ii. Suburbs
   iii. Small City
   iv. Town or Village
   v. Rural Area
   vi. (If vol) “Moved around”

h. Region of Country
   i. Northeast
   ii. Midwest
   iii. South
   iv. West

i. Amount of education completed in years
   i. 0 – 11 Years
   ii. 12 Years
   iii. 13 – 15 Years
   iv. ≥ 16 Years

j. Marital Status 3 Categories
   i. Married/Cohabitating
   ii. Divorced/Separated/Widowed
   iii. Never married

k. Age
   i. (Participant verbally stated age in years)

2. Childhood Sexual Abuse

a. The next two questions are about sexual assault. The first is about rape. We define this as someone either having sexual intercourse with you or penetrating your body with a finger or object when you did not want them to, either by threatening you or using force, or when you were so young that you didn't know what was happening. Did this ever happen to you?
   i. Yes
   ii. No

b. How old were you the first time? (Regarding rape)

i. (Participant verbally stated age in years)

c. Other than rape, were you ever sexually assaulted, where someone touched you inappropriately, or when you did not want them to?
   i. Yes
   ii. No

d. How old were you the first time? (Regarding sexual assault)
   i. (Participant verbally stated age in years)

3. Posttraumatic Stress Disorder

a. DSM-IV Posttraumatic Stress Disorder (LifeT)
   i. Endorsed
   ii. Not endorsed

4. Depression

a. DSM-IV Major Depressive Disorder w/ hierarchy (LifeT)
   i. Endorsed
   ii. Not endorsed

5. Generalized Anxiety Disorder

a. DSM-IV Generalized Anxiety Disorder (LifeT)
   i. Endorsed
   ii. Not endorsed

6. Suicidality

a. Now look at the third of the three experiences on the list, Experience C. Did experience C <u>ever</u> happen to you ? (Experience C is 'You attempted suicide')
   i. Yes
   ii. No

b. How many times did Experience C ever happen to you in your lifetime?
   i. (Participants verbally stated number of times)

7. Use of Services

a. Have you ever in your lifetime been admitted for an overnight stay in a hospital or other facility to receive help for problems with your <u>emotions, nerves, mental health,</u> or <u>your use of alcohol or drugs</u>?

b. Did you ever use an internet support group or chat room to get help for problems with your emotions or nerves?

c. [(Not counting the internet support group,)] Did you ever in your life go to a self-help group for help with your emotions or nerves?

d. Did you ever use a hotline for problems with your emotions or nerves?
e. Did you ever in your life have a session of psychological counseling or therapy that lasted 30 minutes or longer with any type of professional?
f. Did you ever get a prescription or medicine for your emotions, nerves or mental health [(or substance use)] from any type of professional?
g. Did you ever in your lifetime go to see any of the professionals on this list for problems with your emotions, nerves, or your use of alcohol or drugs? (List: A psychiatrist; General practitioner or family doctor; Any other medical doctor, like a cardiologist, gynecologist or urologist; Psychologist; Social worker; Counselor; Any other mental health professional, such as a psychotherapist or a mental health nurse; A nurse, occupational therapist, or other health professional; A religious or spiritual advisor like a minister, priest, or rabbi; Any other healer, like an herbalist, chiropractor, or spiritualist
(Responses to items a – g)
    i. Yes
    ii. No

8. Substance Use

a. DSM-IV Alcohol Abuse (Lifetime)
b. DSM-IV Alcohol Dependence (Lifetime)
c. DSM-IV Drug Abuse (Lifetime)
d. DSM-IV Drug Dependence (Lifetime)
(Responses to items a – d)
    i. Endorsed
    ii. Not endorsed
e. The next questions are about problems you may have had because of drinking. First, was there ever a time in your life when your drinking or being hung over frequently interfered with your work or responsibilities at school, on a job, or at home?
f. Was there ever a time in your life when your drinking caused arguments or other serious or repeated problems with your family, friends, neighbors, or co-workers?
g. The next questions are about medicines that are often used for any reason other than a health professional said you should use them. Have you ever used marijuana or hashish, even once?
h. Looking at Pages 25-26 in your booklet, have you ever used <u>cocaine</u> in any form, including powder, crack, free base, coca leaves, or paste?
i. Looking at Pages 25-26 in your booklet, have you ever used tranquilizers, stimulants, pain killers, or other prescription drugs either without the recommendation of a health professional, or for any reason other than a health professional said you should use them?

j. Looking at Page 25-26 in your booklet, have you ever used any other drug - such as (those listed in your booklet/heroin, opium, glue, LSD, peyote, or any other drug)?
k. First, was there ever a time in your life when your use of [(marijuana or hashish/cocaine/either marijuana or hashish or cocaine /drugs)] frequently interfered with your work or responsibilities at school, on a job, or at home?
l. Was there ever a time in your life when your use of [(marijuana or hashish/cocaine/either marijuana or hashish or cocaine/drugs)] caused arguments or other serious or repeated problems with your family, friends, neighbors, or co-workers?

(Responses to items e – l)

i. Yes
ii. No

9. Other Traumatic Experiences

a. First, did you ever participate in <u>combat</u>, either as a member of a military, or as a member of an organized <u>non</u>-military group?
b. Were you ever kidnapped or held captive?
c. Were you ever exposed to a toxic chemical or substance that could cause you serious harm?
d. Were you ever involved in a life-threatening automobile accident?
e. Were you ever involved in a major natural disaster, like a devastating flood, hurricane, or earthquake?
f. As a child, were you ever badly beaten up by your <u>parents</u> or the people who raised you?
g. Were you ever mugged, held up, or threatened with a weapon?
h. Has someone ever stalked you - that is, followed you or kept track of your activities in a way that made you feel you were in serious danger?
i. Did someone very close to you ever die unexpectedly; for example, they were killed in an accident, murdered, committed suicide, or had a fatal heart attack at a young age?
j. When you were a child, did you ever witness serious physical fights at home, like when your father beat up your mother?
k. Did you ever see atrocities or carnage such as mutilated bodies or mass killings?

(Responses for items a – k)

i. Yes
ii. No